Healthcare, PLC®
Advanced Eye and Foot Care

7406 N. La Cholla Blvd
Tucson, Arizona 85741
520-545-0202
www.headtotoehealthcare.org

PODIATRIC MEDICAL HISTORY QUESTIONNAIRE

Name:____ **Home Phone:**__________________________
Address:____ **Work Phone:**__________________________
City:______________ **State:**______________ **Zip:**______________ **Cell Phone:**__________________________
Birth Date:____/____/____ **Social Security (opt):**______________ **e-mail:**__________________________
Age_____ **Sex** _____ **Ht** _____ **Wt**_____ **Shoe size** ______
Occupation:____
Primary Care Physician:______________________________ **Last Medical Exam:**______________________
Previous Foot Physician:_____________________________ **Last Foot Exam:**_________________________
Who may we thank for referring you?____

1) INSURANCE INFORMATION

Do you have Insurance? Yes☐ No☐ Primary Insurance Company ______________________________
Insurance Policy Holder's Name____________________ **Relationship to patient**______________ **DOB**____________
Insured SSN____________________ **Insured's Employer**____
Secondary Insurance Company ____

☐ **Was the HIPPA – Notice of Privacy Practices form made available to you?**_________**(Please initial)**

2) CHIEF FOOT COMPLAINT

What is your main Foot Problem today?____

Do you have any other Foot problems that need attention?___________________________________

3) HISTORY OF PRESENT ILLNESS

When did the problem begin?____________**Where is the area of the problem?**_________________________

Was it caused by an injury? ☐ **No** ☐ **Yes**____

Any Previous treatment? ☐ **No** ☐ **if Yes, what have you tried?**___________________________________

Rate the your pain from 1 to 10 (ten being excruciating pain) ☐ **0** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐ **8** ☐ **9** ☐ **10**

4) PAST MEDICAL HISTORY

Do you have any of the following medical conditions?

Condition	Yes	No	Condition	Yes	No
Anemia	Yes☐	No☐	Heart Trouble	Yes☐	No☐
Back / Spine pain	Yes☐	No☐	High Blood Pressure	Yes☐	No☐
Blood Disease	Yes☐	No☐	High Cholesterol	Yes☐	No☐
Cancer	Yes☐	No☐	HIV / AIDS	Yes☐	No☐
Circulation Problems	Yes☐	No☐	Kidney Disease	Yes☐	No☐
Depression	Yes☐	No☐	Leg Cramps	Yes☐	No☐
Diabetes	Yes☐	No☐	Osteoporosis	Yes☐	No☐
Epilepsy/Seizure	Yes☐	No☐	Rheumatic Disease	Yes☐	No☐
Eye Disease	Yes☐	No☐	Swelling of limbs	Yes☐	No☐
Gout	Yes☐	No☐	Stomach Trouble	Yes☐	No☐
Hepatitis	Yes☐	No☐	Stroke	Yes☐	No☐
Headaches	Yes☐	No☐	Tuberculosis	Yes☐	No☐

Other Yes☐ No☐ (list)____

Which of the above illnesses are in your immediate family?____

List ANY medications you take prescription or over the counter:____

____

Do you have any allergies to medication? (if so, list)____

List ALL major injuries, surgeries and hospitalizations:____

____

Are you pregnant or nursing? (if applicable) **Yes**☐ **No**☐

5) SOCIAL HISTORY

Marital status / Living arrangement ☐ **Single** ☐ **Married** ☐ **Other**________________________________

Do you use tobacco products? **Yes**☐ **No**☐ **If yes, what type/ amount/ how long?**__________________________

Do you use illegal drugs **Yes**☐ **No**☐ **If yes, what type/ amount/ how long?**__________________________

Do you drink alcohol? **Yes**☐ **No**☐ **If yes, what / how much / how often?**__________________________

Have you ever been exposed to or infected with any sexual transmitted diseases/ HIV? **Yes**☐ **No**☐

Hobbies & Activities?____

6) REVIEW OF SYSTEMS

Do you currently have or chronically suffer from any of the following conditions?

INTEGUMENTARY (Skin)

☐ **Deformed nails**	☐ **Itching**	☐ **Ulcerations**
☐ **Discolorations**	☐ **Skin Cancers**	☐ **Warts**
☐ **Eczema / Psoriasis**	☐ **Skin Rash**	☐ **Other**____________________

HEMATOLOGIC (blood)

☐ **Bleeding disorder**	☐ **Take aspirin**	☐ **Take Coumadin**

NERVOUS

☐ **Muscle jerking**	☐ **Paralysis**	☐ **Weakness**
☐ **Numbness / Burning**	☐ **Sciatica**	☐ **Other**____________________

MUSCULOSKELETAL

☐ **Arthritis**	☐ **Sprains**	☐ **Tendonitis**
☐ **Fractures**	☐ **Stiffness**	☐ **Other**____________________

☐ **Are you aware that we have preliminary screening for Vascular Disease & Osteoporosis available at this office?**

I hereby give Head to Toe Healthcare, PLC permission to treat me or my dependents as necessary. I understand that my insurance company may assist me in paying all/some medical cost, but I am ultimately responsible for all medical services rendered. I agree to pay all reasonable and customary collection fees and/or attorneyøs fees that may be incurred due to any delinquent accounts I may have. I authorize the release of any medical information/records necessary to process my claim to my insurance company/ healthcare facilities for my continuation of care. I also authorize payment of medical benefits to my physician, directly, for services rendered. I understand that I am financially responsible for my bill.

****As a Courtesy, we will bill your insurance company for you****

X____ **Signature Date:**________________________

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Orthotics/ Durable Medical Equipment Policy

H2T is NEVER able to guarantee payment by medical insurance carriers for Orthotics and/or Durable Medical Equipment. H2T will bill your medical insurance as a courtesy, if claims are denied; patient is responsible for payment in full. Self-pay patients are responsible for payment at the time services are rendered.

Due to sanitary reasons and professional health care standards, we do not accept returns on any purchased or dispensed products, even if patient states product has not been used.

X-ray Policy

Certain medical conditions require X-rays for proper diagnosis. X-rays are a separate charge from physician exam fees, and not included in the office visit fee. X-rays are a separate charge billed either to your medical insurance company, or directly to the patient. Self-pay patients are responsible for payment at the time services are rendered.

Pregnant or suspected pregnant patients MUST inform H2T staff regarding their condition. Additionally, if patient has any other medical conditions or concerns regarding X-rays, inform H2T staff immediately so we can best accommodate you.

Study Policy

We are pleased to participate in the advancement and improvement of the latest health care service and product renderings. Therefore, we often conjointly collaborate on various clinical trials. Patients participating in any H2T clinical trials will need an initial evaluation by H2T physician. Medical insurance will be billed for the initial evaluation including X-rays and other associated procedures necessary for proper treatment. Co-payments and all uncovered services will apply. We will advise you of any complimentary or discounted product or service offers in conjunction with a clinical trial.

Workers Compensation (Workman's Comp)

H2T does not participate nor process ANY workers compensation cases or claims.

No Show/ Cancellation Policy

Effective September 1st, 2009, ALL scheduled no show appointments will be charged a $30.00 - no show fee. Patient is responsible to CALL the office to reschedule or cancel any appointment at least 24 hours in advance.

Patients who are running 20 minutes late for his/her scheduled appointment will be rescheduled to the next available appointment/ day.

H2T Office Policy

Photo ID might be required for insurance and physical address verification. Medical cards are required at the time of service for continuation of care. Patient is responsible to notify H2T any insurance changes. Any unverified information will result in the visit being a self-pay.

I, ____, have read and understand the policies stated above.

Signature__________________________________ Date: ________________________

Effective Dec 2011